Homegrown Therapy
Phone: (907) 206-3777 Fax: (907) 206-3800

PATIENT REGISTRATION

Client's Name: _____ Date of Birth: _____ Male/ Female (please circle one)

Parent/Guardian Name(s): _____

Mailing Address: _____

City, State, Zip: _____

Phone: Primary: _____Secondary: _____ Additional:_____

Referring Physician: _____

Phone: _____ Fax: _____

Other Physician(s): _____

Insurance Provider: _____ ID Number: _____

Primary Insured: _____Group Number:_____

Primary Insured Date of Birth_____

Secondary Insurance: _____ ID Number: _____

Secondary Insured: _____Group Number: _____

Secondary Insured Date of Birth_____

Diagnosis or Description of Problem: _____

_____

Allergies and/or Medications:
_____

Injuries or Surgeries: _____

Prior or Current PT/OT/SLP Services (circle)

Emergency Contact: _____Phone: _____

I certify that the information above is true to the best of my knowledge.

_____ _____
Client/Parent/Guardian **Date**

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CONSENT FOR TREATMENT, CONSENT TO PHOTOGRAPH/USE PHOTOGRAPHS ON WEBSITE, AND BILLING/NO SHOW POLICY

Client's Name: _____Date of Birth: _____

Consent to evaluate and treat:
I hereby authorize the occupational, physical and speech therapists of Homegrown Therapy to evaluate myself or my dependent for the appropriateness of rehabilitation services. I understand that the findings will be used only in the best interest of myself or my dependent. I understand that the findings will be discussed in full with me.

I understand that the complete Plan of Care will be discussed with me in full and treatment is designed in the best interest of myself or my dependent. _____ **(please initial)**

Consent to Photograph:
I hereby give permission to the therapists of Homegrown Therapy, to use photography or videotaping for the following purpose:

- Documentation of current status for baseline or comparison to earlier date
- For communication with other medical practitioners
- For educational purposes.

Any questions or concerns regarding the use of photography or videotape have been addressed by my primary therapist
Consent to Photograph_____ (please initial) Do not Consent to Photograph_____ (please initial)

Consent to Use Photographs on Website:
I hereby give permission to the therapists of Homegrown Therapy to take photographs and use videotaping for display on the Homegrown Therapy website for the purpose of introducing new clients to this practice and to the benefits of Occupational Therapy, Speech Therapy, and Physical Therapy.

Any questions or concerns regarding the use of photographs or videotapes have been addressed by my primary therapist.

Consent to Use Photographs on Website_____ (please initial)
Do not Consent to Use Photographs on Website_____ (please initial)

Billing Policy:
I authorize payment of medical benefits to Brooke McDaniel, billing under Meaningful Things Therapy LLC. I understand that payment of therapy charges is ultimately my responsibility. I agree to pay my portion of the insurance deductible, co-insurance or co-payment within thirty (30) days of receiving the bill. _____ **(please initial)**

No Show Policy:
Due to the growing number of missed appointments without prior cancellation, we reserve the right to charge a no show fee of $25.00. Please see our COMMITMENT AND ATTENDANCE POLICY. _____ **(please initial)**

By signing and initialing, I authorize and **Consent to Evaluate and Treat, Consent to Photograph, Consent to Use Photographs on Website,** and understand and agree to the **Billing and No Show Policy.**

_____

Parent or Legal Guardian **Date**

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AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Regarding: _____ Date of Birth: _____

I authorize Homegrown Therapy to (check all that apply):

_____ Receive and use the following protected information, and/or
_____ Disclose the following protected information to:

_____
(Name of person/organization to exchange information)

Specific description/type of information:
(ex. Evaluation, report, IEP, progress report/notes, eligibility information, financial, and dates)

This protected information is being used or disclosed for the following purposes:

This authorization will expire on _____/_____/_____ (MM/DD/YY)

I understand this authorization is voluntary and may be revoked at any time by signing the revocation section on this form, or by notifying the individual(s) or organization releasing this information in writing; the revocation will not have any effect on any prior actions taken. I understand that I may receive a copy of this authorization and view and/or copy the information described on this authorization.

_____ Date_____
Individual's Signature

NOTE: This authorization was revoked on: _____

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ATTENDANCE POLICY

If you are unable to come to appointments on a consistent basis, we will place your child on a temporary waiting list and make your time slot available to others who need it. This temporary list will just be a list of clients that need time slots and you will not have to go through initial enrollment again. Unless we have a critical referral that needs our immediate attention, this list will be prioritized over our new client waiting list. Keep in mind that if nobody needs your slot, it will be available when you are able to attend regularly again. Inconsistent attendance will be defined as the following:

- An attendance rate of less than 75% over the course of three months
- Vacations, sickness or hospitalizations that exceed 4 weeks
- Three no call/no shows within a six-month period.
- If there are three no call no shows within a three-month period, you will be discharged permanently from treatment unless there is a very compelling reason.

If you anticipate any of these inconsistencies in your schedule, please inform us ahead of time so we can make reasonable arrangements, give you reminder calls if needed, choose to enroll your child when you are available for regular appointments, or opt for calling first thing in the morning and scheduling your child in an available slot. Please tell our office manager, Nickie, if you would like weekly reminder calls.

_____ Date_____

Parent/ Guardian Signature

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PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment, and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our Legal Duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Brooke McDaniel, OTD, OTR/L at the above business line.

Acknowledgement of Receipt of Notice of Privacy Practices:
Please sign your name, print your name, and date this form.

Signature:_____ Date:_____

Printed Name:_____

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RELEASE OF LIABILITY

I agree to release Homegrown Therapy and any of its providers and will hold them harmless from any liability (including injury or illness) which may arise from incidents or accidents involving my child/children, while participating in occupational therapy services at any location, or while on the Homegrown Therapy premises.

Consent to Release Liability_____ (please initial) **Do not Consent _____ (please initial)**

I agree to allow any Homegrown Therapy provider to administer basic first aid, and in the event of an emergency, to administer first aid medications such as Benadryl or Epinephrine pens*.

Consent to Administer_____ (please initial) **Do not Consent _____ (please initial)**

**Epi-pens or other personal emergency medications must be provided by parent*

This release form will be valid for the following child/children, for the duration of care at Homegrown Therapy:

_____

_____

_____

_____

_____ _____
Name of parent/guardian Date

_____
Signature of parent/guardian